Precedent Setting Legal Cases

Three court cases setting legal precedent for mental health boards may have an impact on commitment decisions and should be noted: those of Olmstead, Wickwire, and Albert. These cases involve (1) the mandate for least restrictive placement; (2) the lack of jurisdiction over a person with mental retardation; and (3) the importance of obtaining the required training set by law for mental health board members.

The Olmstead v. L.C., 527 U.S. 581 (1999) case involved a person held in a Georgia mental institution who wanted community placement. Using the Americans with Disabilities Act as reference, the Supreme Court found that it is discriminatory to provide services in an institution when an individual could be served more appropriately in a community-based setting. It was argued that unjustified retention is a form of discrimination limiting exposure to the outside community; that a person's rights were violated when held in an inappropriate level of care. The ruling applies when treatment professionals determine community placement appropriate and transfer from institutional care to community setting is agreed to by the individual. Also, the placement must be reasonably accomplished by the state, taking into consideration the resources of the state and the needs of the mentally ill person.

Nebraska's decision In re Wickwire 259 Neb. 305, 609 NW2d 384 (Neb. 2000) concerned an individual with an IQ of 40, considered to be mentally retarded who did not have a diagnosis of mental illness. His developmental disability included serious behavioral issues and, due to his aggressive and violent behavior, the Lancaster County Attorney filed a mental health board petition stating that Wickwire was a mentally ill and dangerous person, recommending inpatient placement at the Lincoln Regional Center. However, psychiatrists at Lincoln Regional Center testified that treatment at a psychiatric hospital would not benefit Wickwire, due to his

diagnosis of mental retardation, not mental illness. The court ruled that although the mental health board found him a dangerous person, they had no jurisdiction over persons with mental retardation; and that the state of Nebraska did not intend the terms "mental illness" and "mental retardation" to be used interchangeably.

In another Nebraska District court case, from Platte County District court, (August 24, 2001), a mental health board decision was declared null and void because two of the three board members had not completed mental health board training as required by statute within the past two years as required by statute. Statute 71.916 still makes mental health trainings mandatory. Albert had served time in prison for first degree sexual assault. At the time of his release, a petition was filed under the Mental Health Commitment Act and he was committed to Norfolk Regional Center as a mentally ill and dangerous person. Albert brought a writ of habeas corpus, alleging that he was unlawfully imprisoned because the actions of the board were void, due to their not having followed the law requiring yearly training for board members. The court found for Albert and he was discharged.

New Law/Cases

1. The new Mental Health Commitment Act, NRS Sec. 71-901 et seq., became effective July 1, 2004. There were two changes in the MHCA that became effective July 1, 2005.

(i.) **NRS Sec. 71-906**. The legislature expanded the definition of "mental health professional" to include an advanced practice registered nurse who has certification in a mental health specialty, as well as a person licensed to practice medicine and surgery or psychology.

(ii.) **NRS Sec**. **71-922**. The legislature mandated that board proceedings are deemed to have commenced upon the earlier of (a) the filing of a petition or (b) notification by the county attorney to the law enforcement officer who took the subject into emergency protective custody or the administrator of the treatment center having charge of the subject of his or her intention to file such petition. The county attorney shall file such petition as soon as reasonably practicable after such notification.

2. **In re Interest of E.M.**, 13 Neb. App. 287 (2005) examined 83-1045.02, which provides that "no person may be held in custody pending the hearing for a period exceeding seven days, except upon a continuance granted by the board." The language remains essentially the same in

the new MHCA at 71-934, which provides "no person may be held in custody under this section for more than seven days except upon a continuance granted by the board".

The subject in E.M. was taken into custody on September 17, 2003 and the hearing was held on September 25. The subject argued that he was denied his statutory right to a hearing within 7 days of being taken into custody.
Held: "The 'seven days' language of Section 83-1045.02 is directory, not mandatory, and that even assuming the provision was violated in this case, violation of the provision does not mandate dismissal of the proceedings." 13 Neb. App. 287 (2005) at 294.

3. In re Interest of Verle O., 13 Neb. App. 256 (2005). In 1993, Verle entered a plea of "no contest" to attempted first-degree sexual assault on a child in a criminal case and was incarcerated. Nine years later, at the time the Verle was to be discharged from the department of corrections, the state filed a petition with the mental health board alleging Verle was mentally ill and dangerous. Under Section 83-1009 [re-codified at 71-908], there must be a recent violent act, a threat of violence, or an act placing others in reasonable fear in order to find that a person is dangerous. The Board found Verle to be mentally ill and dangerous, but failed to specify any specific recent violent act or threat of violence that would make Verle dangerous as required by statute. Instead, the board relied on the no contest plea and statements made on the record by Verle at that plea hearing as the factual basis for finding Verle mentally ill and dangerous.

Held: By entering a plea of no contest (as opposed to entering a guilty plea), Verle avoided making any admissions of fact; therefore, any statements made by Verle in connection with the no contest plea were not admissible as evidence in the civil commitment proceeding. The mere fact that Verle plead no contest to an attempted assault does not in and of itself establish that Verle performed recent violent acts as required by statute. Additional facts must be established to sustain a commitment.

Board Determination of Mental Illness

1. Overview of Mental Illness

The first determination a mental health board must make is whether a person is mentally ill, alcoholic, or drug abusing. In the scope of the commitment process, "mentally ill" is considered to include alcoholics and drug abusers. Mental illness is not defined in the Act. A psychiatrist, a licensed clinical psychologist or a APRN is allowed by law to diagnose mental illness and will present an evaluation of the person appearing before the board. By statute a licensed alcohol and drug abuse counselor (LADAC) can diagnose substance dependency and other substance abuse issues. If board members have questions about the reported diagnosis,

symptoms, or behaviors of a person appearing before them, it is important to question the mental health professional or LADAC and to receive answers.

Clinicians use the latest edition of DSM, the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as the standard for diagnostic criteria in determining mental illness. There are five Axis categories in a diagnosis:

Axis I -- Mental Illness, and or substance abuse or ..dependence

Axis II -- Personality disorders, mental retardation

Axis III -- Physical conditions and disorders

Axis IV -- Psycho-social and environmental problems, stresses (housing, support group, occupation, education, social, legal system problems, accessing health care)

Axis V -- GAF (Global Assessment of Functioning; the rate of current overall occupational, psychological and social functioning expressed as a single number on a 1 to 100 point scale) Low to Normal = 75-100.

Mental illness can be viewed as a collection of symptoms, either behavioral or psychological, which cause an individual distress, disability, or an increased risk of suffering, pain, disability, death, or loss of freedom. Mental illness can be a thinking disorder such as schizophrenia with its characteristic delusions and hallucinations; or a mood disorder with depression; anxiety, panic disorder; a bipolar disorder which may have cycles of depression and mania; behavior disorders; personality disorders; or alcohol and drug dependence disorders.

A mental status examination is an evaluation of a person's current mental functioning, which aids a clinician in arriving at a diagnosis. A typical mental status exam (MSE) covers the following areas:

- Appearance and Behavior: dress, grooming, posture, physical characteristics, facial expression, eye contact, motor activity, cooperation

- Speech: rate, loudness, amount, clarity
- Emotions: mood—depressed, anxious, euphoric, angry
- Thought: Suicidal or homicidal ideation, logic, flow of ideas, content, delusions, preoccupations or obsessions, phobias
- Perception: presence of auditory, visual, tactile, olfactory hallucinations
- Insight and Judgment: orientation to time, place, person, concentration, memory, fund of knowledge, judgment, insight or awareness of mental illness, intelligence

2. Overview of Substance Abuse versus Substance Dependence

Substance abuse or substance dependency are terms often heard when a board listens to testimony at a hearing. It is necessary to differentiate between abuse and dependency. *Substance addiction, substance dependence and chemical dependency* refer to an **addiction**, while *substance **abuse** is temporary use of alcohol or other drugs which cause problems in a small part of an individual's life.* Abusers are able to recognize the relationship between their alcohol and/or drug use, the problems it causes and can stop their abuse with a little help and encouragement.

In dependence, use of the substance becomes progressively worse. A diagnosis of dependency includes meeting the criteria of increased tolerance, withdrawal symptoms, and a pattern of compulsive use. Persons who are dependent continue using substances in spite of increasingly severe consequences in personal and social lives and physical health.

Common symptoms of dependency are: 1) increasing episodes of intoxication; 2) loss of interest in other pursuits; 3) loss of control over usage; 4) repeated remorse over the results of substance use; 5) increased tolerance to the drug (including alcohol); 6) negative reactions to withdrawal from the drug (Best direct evidence of alcoholism is the appearance of withdrawal symptoms one to two days after last drinking alcohol); 7) memory failures as a result of use; 8)

serious personal and social consequences resulting from substance use such as problems with relationships, work, or with the law.

Intoxication by itself doesn't indicate dependency. However when episodes of intoxication occur with increasing frequency, involving larger amounts of a substance due to tolerance, resulting in increasingly severe personal and social consequences over an extended period of time--a diagnosis of dependency is almost certain. Other indicators for alcohol dependence are:

- Drinking at or before breakfast
- Drinking non-beverage forms of alcohol (Rubbing alcohol, cologne, etc.)
- Traffic difficulties (DUI, DWI arrests)
- Problems at work related to alcohol use
- Relationship problems related to usage; fighting associated with drinking
- Inability to stop drinking even if the person has wanted to
- Drinking binges
- Black outs (a person has no memory of his behavior or events although during that time he appeared conscious and aware)

3. Overview of "Dual Disorders & Dual Disorder Treatment"

As more and more persons present with multiple problems and illnesses in the commitment process, there is an increasing need to understand the differences between dual disorders, dual disorder treatment and dual enhanced treatment for co-occurring disorders. Understanding the differences between these levels of duality will help the Mental Health Board be able to make appropriate decisions for the least restrictive placement of a person depending upon the severity of the dual issues presented.

A **dual disorder** occurs when an adult has a primary Axis I severe and persistent mental illness (SPMI) diagnosis and a primary Axis I substance dependency diagnosis. It is important to remember that there are only a few mental illnesses that are included within the category of **severe and persistent mental illnesses**: schizophrenia or schizoaffective disorder, bipolar disorder, major depression, and other psychotic disorders. It is also important to know that substance dependency is much more severe and chronic than substance abuse. **Dependency** is a pattern of repeated substance use that results in tolerance, withdrawal, and compulsive substance-taking behavior, where substance abuse does not include these characteristics. The essential feature of dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating continued use despite significant substance-related problems. In combination, these two diagnoses (SPMI/SD) present unique problems for Mental Health Boards in determining the least restrictive treatment placement while ensuring public safety.

There are only a few persons that meet this severe level of dual disorder. The Mental Health Board should carefully determine if the subject in the hearing has this level of severity to be considered dually diagnosed. Dual disorder clients eligible for **dual disorder treatment** will exhibit more unstable or disabling levels of SPMI and dependency. The typical client is disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in simultaneous addiction treatment. It is also important to determine if the acute symptoms are stabilized or, if the subject needs further stabilization before being able to benefit from a dual treatment program. The subject must not display symptoms of intoxication and must be stable on psychotropic medication(s) in order to be admitted to a community based dual treatment program. Often a short stay at an acute inpatient program for psychiatric stabilization, and then a move a community based dual disorder

residential treatment program provides the most appropriate primary integrated treatment to address both the mental illness and the substance dependency problems simultaneously.

When a person with a mental illness such as schizophrenia acquires a substance dependency, serious consequences result. There can be more severe impairments while using lesser quantities, less frequently. There is a higher risk of non-compliance with mental health treatment, in fact, they are eight times more likely to be non-compliant with medications. Psychiatric symptoms fluctuate more rapidly and are more severe. In addition, there are increased mood swings, more psychiatric re-hospitalizations, violent acting out behavior, suicidal ideation, and suicide attempts. If a person with substance dependency has established an entrenched pattern of chronic use, hallucinations, manic behavior, suicide ideation and delusionary behavior can occur resulting from the habitual use of substances.

A person with a dual disorder requires specific psychiatric and mental health support and monitoring in order to participate in treatment for alcohol and/or drug addiction. Due to the multiple problems, they need an individualized and flexible approach to treatment. The supportive, non-threatening approach is more therapeutic for a dually diagnosed person whereas a confrontive approach would be difficult to tolerate, especially if symptoms of paranoia are present.

4. "Overview of Co-Occurring Disorders & Dual Enhanced Treatment"

An increasingly common diagnosis is when the subject has a primary mental illness and a secondary substance use or abuse disorder, OR a primary substance abuse disorder and a secondary mental illness. These combinations of dual issues are termed C**o-occurring disorders** and are appropriate for **dual enhanced treatment.** Dual enhanced treatment is for persons whose mental illness or substance disorder is less active than the primary

diagnosis. Providers(mental health or substance abuse) of these treatment services may elect to "enhance" their primary service to address the client's other relatively stable diagnostic or sub-diagnostic co-occurring disorder. The primary focus of such programs is either mental health OR abuse/dependency treatment rather than dual diagnosis concerns and is not a primary, integrated dual disorder treatment.

Alcohol is the substance most frequently used by persons with mental illnesses, followed by cocaine, marijuana and methamphetamine. About 50% of persons in a psychiatric clinical setting will have a substance disorder. The lifetime prevalence of a substance disorder in persons with schizophrenia is 47%; in those with bipolar disorder, it is 56%; and in those with major depression, it is 27%. Research studies show that 29% of people with an Axis I psychiatric disorder will have a substance abuse disorder at some time in their lives. Persons with mental illness report similar reasons as the general population for using substances: attempting to improve unpleasant moods such as anxiety and depressions, increasing social interaction, and increasing pleasure by feeling "high". While mentally ill persons may use substances in order to deal with symptoms, people without mental illness can display psychotic symptoms due to substance use, such as anxiety, panic, mood swings, hallucinations, delusions, amnesia, personality changes, insomnia, and eating-disordered behavior. Both dependence and psychosis feature loss of control of behavior and emotions, and in both instances symptoms respond to treatment.

It is difficult for strictly substance abuse treatment agencies to serve a dually disordered person in their population just as it is difficult for strictly mental health treatment agencies to serve the dually diagnosed person. It is important to note that Nebraska's Regional Centers provide dual enhanced treatment for co-occurring disorders only. They do not have integrated

dual disorder treatment programs nor are they equipped to served the dually diagnosed client. The specific mission of the Regional Centers in Nebraska is to provide acute inpatient and secure residential mental health services. While they have a few licensed alcohol and drug abuse counselors on staff to do dual enhanced programming, treating substance dependency and substance abuse is not a role for the Regional Center. The expertise in substance treatment in Nebraska is in community based programs.